Extends the health facility quality assessment fee until August 1, 2013. (The current quality assessment fee is scheduled to expire August 1, 2009.) (The introduced version of this bill was prepared by the select joint commission on Medicaid oversight.)

SECTION 1. P.L.3-2007, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: SECTION 1. (a) As used in this SECTION, "health facility" refers to a health facility that is licensed under IC 16-28 as a comprehensive care facility.

(b) As used in this SECTION, "nursing facility" means a health facility that is certified for participation in the federal Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(c) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(d) As used in this SECTION, "total annual revenue" does not include revenue from Medicare services provided under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(e) Effective August 1, 2003, the office shall collect a quality assessment from each nursing facility that has:

(1) a Medicaid utilization rate of at least twenty-five percent (25%); and

(2) at least seven hundred thousand dollars ($700,000) in annual Medicaid revenue, adjusted annually by the average annual percentage increase in Medicaid rates.

(f) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under this SECTION using the methodology described in subsection (e), the office shall revise the state plan amendment and waiver request submitted under subsection (l) as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii). The revised state plan amendment and waiver request must provide for the following:

(1) Effective August 1, 2003, collection of a quality assessment by the office from each nursing facility.

(2) Effective August 1, 2003, collection of a quality assessment by the department of state revenue from each health facility that is not a nursing facility.

(3) An exemption from collection of a quality assessment from the following:

(A) A continuing care retirement community.

(B) A health facility that only receives revenue from Medicare services provided under 42 U.S.C. 1395 et seq.

(C) A health facility that has less than seven hundred fifty thousand dollars ($750,000) in total annual revenue, adjusted annually by the average annual percentage increase in Medicaid rates.

(D) The Indiana Veterans' Home.

Any revision to the state plan amendment or waiver request under this subsection is subject to and must comply with the provisions of this SECTION.

(g) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under this SECTION using the methodology described in subsections (e) and (f), the office shall revise the state plan amendment and waiver request submitted under subsection (l) as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii) and to provide for collection of a quality assessment from health facilities effective August 1, 2003. In amending the state plan amendment and waiver request under this subsection, the office may modify the parameters described in subsection (f)(3). However, if the office determines a need to modify the parameters described in subsection (f)(3), the office shall modify the parameters in order to achieve a methodology and result as similar as possible to the methodology and result

described in subsection (f). Any revision of the state plan amendment and waiver request under this subsection is subject to and must comply with the provisions of this SECTION.

(h) The money collected from the quality assessment may be used only to pay the state's share of the costs for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as follows:

(1) Twenty percent (20%) as determined by the office.

(2) Eighty percent (80%) to nursing facilities.

(i) After:

(1) the amendment to the state plan and waiver request submitted under this SECTION is approved by the United States Centers for Medicare and Medicaid Services; and

(2) the office calculates and begins paying enhanced reimbursement rates set forth in this SECTION;

the office and the department of state revenue shall begin the collection of the quality assessment set under this SECTION. The office and the department of state revenue shall establish a method to allow a facility to enter into an agreement to pay the quality assessment collected under this SECTION subject to an installment plan.

(j) If federal financial participation becomes unavailable to match money collected from the quality assessments for the purpose of enhancing reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office and department of state revenue shall cease collection of the quality assessment under this SECTION.

(k) To implement this SECTION, the:

(1) office shall adopt rules under IC 4-22-2; and

(2) office and department of state revenue shall adopt joint rules under IC 4-22-2.

(l) Not later than July 1, 2003, the office shall do the following:

(1) Request the United States Department of Health and Human Services under 42 CFR 433.72 to approve waivers of 42 CFR 433.68(c) and 42 CFR 433.68(d) by demonstrating compliance with 42 CFR 433.68(e)(2)(ii).

(2) Submit any state Medicaid plan amendments to the United States Department of Health and Human Services that are necessary to implement this SECTION.

(m) After approval of the waivers and state Medicaid plan amendment applied for under subsection (l), the office and the department of state revenue shall implement this SECTION effective July 1, 2003.

(n) The select joint commission on Medicaid oversight, established by IC 2-5-26-3, shall review the implementation of this SECTION. The office may not make any change to the reimbursement for nursing facilities unless the select joint commission on Medicaid oversight recommends the reimbursement change.

(o) A nursing facility or a health facility may not charge the facility's residents for the amount of the quality assessment that the facility pays under this SECTION.

(p) The office may withdraw a state plan amendment under subsection (e), (f), or (g) only if the office determines that failure to withdraw the state plan amendment will result in the expenditure of state funds not funded by the quality assessment.

(q) If a health facility fails to pay the quality assessment under this SECTION not later than ten (10) days after the date the payment is due, the health facility shall pay interest on the

quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

(r) The following shall be provided to the state department of health:

(1) The office shall report each nursing facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality assessment is due.

(2) The department of state revenue shall report each health facility that is not a nursing facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality assessment is due.

(s) The state department of health shall do the following:

(1) Notify each nursing facility and each health facility reported under subsection (r) that the nursing facility's or health facility's license under IC 16-28 will be revoked if the quality assessment is not paid.

(2) Revoke the nursing facility's or health facility's license under IC 16-28 if the nursing facility or the health facility fails to pay the quality assessment.

(t) An action taken under subsection (s)(2) is governed by:

(1) IC 4-21.5-3-8; or

(2) IC 4-21.5-4.

(u) The office shall report the following information to the select joint commission on Medicaid oversight established by IC 2-5-26-3 at every meeting of the commission:

(1) Before the quality assessment is approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the progress in receiving approval for the quality assessment; and

(B) a summary of any discussions with the United States Centers for Medicare and Medicaid Services.

(2) After the quality assessment has been approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the collection of the quality assessment;

(B) a summary of the quality assessment payments owed by a nursing facility or a health facility; and

(C) any other relevant information related to the implementation of the quality assessment.

(v) This SECTION expires August 1, ~~2009.~~ **2013.**